

Welcome to Our Office

For faster service, please complete the following form prior to arriving at our office.

Appointment Date _____ Single Married Widowed

Patient's Name (please print) _____

If a child, Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail Address _____

DOB _____ M or F SSN _____

Employer _____ Occupation _____

Spouse's Name _____ DOB _____ SSN _____

Spouse's Employer _____ Occupation _____

Date of Last Eye Exam _____ Dr.'s Name _____

How did you here about our office? _____

Insurance Information

Vision Insurance Carrier _____ Policy # _____

Insured's Name _____ DOB _____

Health Insurance Carrier _____

Policy # _____ Group # _____

Primary Insured's Name _____ DOB _____

Do you have a secondary Health Insurance? Yes No _____

I request that payment of authorized Medicare benefits or the above carrier, be made to David A Johnson OD or Nancy S Barr OD for any services rendered to me. I authorize any holder of medical information about me to be released to Health Care Financing Administration and its agents any information needed to determine payment for these related services. I understand my signature requests that payment be made and authorizes release of medical information and if "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of information necessary to pay the claim. I understand I am responsible for the deductible, coinsurance, and non covered services.

Signature X _____ Date _____

Medical Information

Personal Medical Information: Do you have problems with any of these systems?

If yes, please check box.

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergic/ Immunologic | <input type="checkbox"/> Gastro Intestinal | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Blood/Lymph | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Nervous System |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Mental | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Endocrine (Glands) | <input type="checkbox"/> Surgeries | |

If surgeries what type & when _____

Any allergic reactions to medications or other substances? Yes No If yes, please list below _____

Name of general physician _____

Please Check: Yes or No

Do you wear glasses? Yes No

Do you wear contacts? Yes No Are you interested in contacts? Yes No

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much? _____

Do you take medications? Yes No Please list names & how often: _____

Family History: Please check box if you or your family have had the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Bloodshot Eyes | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Color Vision |
| <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> Eye Infection | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Itching Eyes | <input type="checkbox"/> Seeing Halos |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Seeing Flashes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Watering Eyes |
| <input type="checkbox"/> Discharge from Eyes | <input type="checkbox"/> Floaters/ Spots | | |

Please explain any boxes you have checked: _____

Are you interested in laser vision correction? Yes No

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature X _____ Date _____

Notice of Privacy Practices

EyeCare Plus
David A. Johnson, O.D. & Nancy S. Barr, O.D.
301-B Petrol Pt
Peachtree City, GA 30269

Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name _____ **Birthdate** _____

Signature X _____ **Date** _____